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Vol. XVI JUNE, 1946 No. 6

CONTENTS

How Parents Hinder Adolescents' Adjustments to the Opposite Sex 151
S. R. Laycock

"Screening" Eye Examinations and Follow Up (Continued) 157
National Society for the Prevention of Blindness

The School Health Service Program—A Talk to Parents 163
Dorothy Tipple

Surgical Treatment of Intractable Plantar Warts 169
J. A. Dickson, M.D.

Editorial 168

Abstracts and Notes 156, 162, 167, 171

Bibliography 180

Meetings 180

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THE JOURNAL OF SCHOOL HEALTH

Devoted to the interests and advancement of school health service and instruction.
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Vol. XVI JUNE, 1946 No. 6

HOW PARENTS HINDER ADOLESCENTS' ADJUSTMENTS TO THE OPPOSITE SEX**

S. R. LAYCOCK*

Most parents do little thinking about the development of the love life of their children. They are apt to think that the child is born with affection for his parents and family, and that by some mysterious process he falls in love during late adolescence. Actually the love life of a human being has a long history. It starts with childhood and should develop through four stages, culminating in adult heterosexuality—that is, falling in love with the opposite sex, the choice of a mate, and marriage.

The Growth of the Love Life

The Infancy Period. When a baby is born he is entirely self-centered. He is interested solely in his own desires and impulses. He has, however, other needs as well. Among these is the need for affection from his mother. The baby finds that, in order to have the affection of his mother, he has to some degree to give up doing as he likes. He therefore tries to win her approval by meeting her wishes to some extent. In growing up, therefore, the baby goes through twin processes of gratification and renunciation. He wants to do as he likes, but he also wants the love and approval of his mother and father and later of others. In the normal home the child makes gradual progress in learning to give up things in return for emotional security and the approval of others. This is what educators call "socializing" the child, and it continues all the way to adulthood. Stable adults who are good citizens are those who have reached a nice balance between gratifying their own desires and meriting the approval and affection of others by the things they do from day to day.

The Latency Period of Development. This period of the love life is a period when sexual and other affectional interests are not

*Dr. Laycock is known to many readers of *Understanding the Child* from his articles in previous issues of the magazine. He is director of the Division on Education and Mental Health of the National Committee for Mental Hygiene (Canada). In the present article Dr. Laycock analyzes the various ways in which parents—often unwittingly—interfere with the development of a normal sex adjustment of children.

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absent. They are, actually, in an important stage of development. The child at this period becomes multi-centered. He becomes interested in his playmates and school fellows and in ideal heroes. He is secure in the affection of his parents, but he is no longer totally dependent upon it. This is a period of gangs with a good deal of loyalty to the gang rather than intense personal loyalties. There is apt to be an interest in many companions of the same sex.

The Homosexual Period. In transition from the period just described many children pass through a period of "crushes" on members of their own sex. This is a step away from the multi-centered period to a phase of growth of the love life where the child is intensely attached to one person of the same sex. In our society girls seem to be more prone to this than boys. They often form intense friendships with their school mates and they frequently get crushes on a favorite woman teacher in the high school. Boys also are apt to form intense friendships on this level, however. One of the tragedies of life is that both boys and girls may never grow out of this phase of the development of their love life but remain fixed on the homosexual level and continue to direct their affection to members of their own sex.

The Heterosexual Period. The goal toward which the development of the child's love life is directed is that of heterosexual love, where the boy or girl becomes interested in the opposite sex and falls in love, and eventually, after having "shopped around" with a number of different friends of the opposite sex, chooses a mate for life-long companionship and devotion. This is adult love life. It is through this and through this only that a man or woman can find happy satisfaction in their love life. A happy marriage and a happy home life with mate and children should be a goal towards which all parents guide their boys and girls.

The above is a brief statement of the development of the love life of the ordinary child. We shall now consider how parents often hinder this phase of the development of their children.

Hindrances to the Development of Adult Love Life

A child's first attitude to his own body and to sex comes from his parents, chiefly from his mother. The attitudes of adolescents towards sex—whether they view it as wholesome and normal, or shameful and disgusting—are, to a considerable extent, the result of the way they were handled in babyhood. The genital organs are closely associated with the organs of elimination. As a result, if the child is greatly shamed when he soils himself or wets himself he is apt to develop guilt feelings with regard to the eliminative processes. These are apt to carry over to that whole region of his

body, so that he is apt to think of things connected with sex as also dirty and disgusting. In addition, every young child explores his body. His fingers and toes are quite a discovery and he plays with them as with a new toy. He is almost bound to discover his genitals in the same way and to play with them. If the mother becomes very emotional about this procedure, and the child is severely punished, his first attitudes to sex are apt to be guilt-feelings and feelings that the whole area and process connected with sex is shameful and dirty. How important are early attitudes established by the mother is seen in the case of many maladjusted adults who claim to be very "emancipated" with regard to sex. Although they may be intellectually "emancipated," they may have great emotional conflicts and a sense of guilt due to the basic feelings developed in them in their early childhood. A mother will help her child best by taking a matter-of-fact attitude toward both the eliminative process and the child's exploration of his body.

It was suggested above that the development of a child is an alternating process of gratification and renunciation in which the child gives up certain things for the security of affection from his mother and father. If for some reason, however, the parents do not give the child love and affection, he finds himself cheated out of his part of the bargain. As a result he finds that there is no real purpose in giving up his selfish impulses and desires. His growing-up socially is thus interfered with. This is one of the reasons why so much delinquency is found in children who come from homes which are broken, or cracked, or where there is harshness or favoritism and where the children are made to feel insecure. The delinquent boy, cheated of the love and affection he should have for his own developing emotional life, settles for the security and approval of the gang of tough boys. Sometimes, too, the adolescent who is cheated of emotional security turns to delinquency as a form of resentment and revenge. Such a child has not the opportunity to have his affectional life grow in a normal fashion. Sometimes he is unable ever to give his affection to his pals or to the opposite sex, or even to make friends, because his basic experiences with human beings have been those of cruelty, meanness, unfairness, and the like.

The over-protected child also fails to grow up. He is often kept from normal play contacts with his age-mates. As a result, when he comes to the age where he should be interested in a great many of his pals he does not know how to play with them and feels insecure and inadequate among them. He is likely to remain dependent on his mother in an infantile form of love life. It is

not an accident that a very large proportion of adult male homosexuals who suffer from arrested development of their love life are unduly attached to their mothers. A homosexual is one who falls in love with the same sex. While some such are worthy citizens, many are anti-social. They may "monkey" with younger boys and arrive in court as a result. Often the mothers of homosexuals have been of the "too devoted" mother type. They are the kind who make tremendous sacrifices for their children, but who demand all of their children's love in return. Emotionally insecure themselves, they sap the life blood of emotional security out of their children and seriously hinder, if not thwart, the growth of the child's love life. Such parents are what Frankwood E. Williams called "innocent but dangerous parents."

One of the most serious ways in which the growth of the love life of children is interfered with by parents is in cases where the parents wanted a boy baby and were unwilling to accept the girl who arrived. In such a case the father may try to treat the little girl as a boy, giving her boys' toys and encouraging her to play boys' games and to develop masculine characteristics. As she grows up this mannish type of girl may find it very difficult, if not impossible, to accept the feminine role in our society. Sometimes she never marries. If the situation is reversed and the mother wanted a girl when a boy baby arrived the result may be even more tragic. The mother treats the boy as "her girl," has him help about the house, teaches him fancywork, and encourages him in feminine manners and interests. Such a boy is likely to remain dependent on his mother with an infantile type of affection. This is because his mother has made it impossible for him to be a part of the gang and to take an interest in age-mates of his own sex at the age when this should occur. Such boys will find it very difficult when they reach adolescence to accept the male role in our society. Some of them never do accept it.

The possibility of establishing a happy adult love life is often interfered with in the case of homes where the parents are not truly partners. The first pattern of masculinity for either a boy or girl is the father. Likewise the first pattern of feminity is the mother. Deep-seated ideas and attitudes as to the role of men and women in the home are laid down in the child's early life. If the mother is the dominating partner in the home and the father is merely a pay-check or a meek and willing servant, that is the pattern which a child has deeply ingrained in him as to the relationship between a man and a woman. On the other hand, if the father is lord and master and the wife is treated like a domestic

servant or a slave, that, too, will be the pattern which the child will have as to what a home should be like. The child, as he grows up, will tend to build his own love life on these patterns.

Another way in which parents hinder their children from attaining an adult love life is to keep them ignorant of all sex matters, or what is worse, to allow the street corner groups to build up their children's attitudes towards sex. A great deal of maladjustment in marriage is due to unwholesome attitudes toward the whole question of men and women relationships. In such cases the parents have kept the child ignorant of sex, or have let him pick up mistaken or, worse still, unwholesome attitudes.

Parents also hinder the best development of the love life of their children by trying to keep them from companionship with the opposite sex for as long as possible. Such parents try to postpone their boy's interest in girls and in dating until the late teens or even into the twenties. Similarly they try to postpone their daughter's association with boys for as many years as possible. Such an attitude on the part of parents in keeping adolescents away from the opposite sex has several dangers. First of all, there is the danger that the emotional life of the adolescent will be so stunted that he or she will never be able to achieve adult heterosexuality, that is, to fall in love with the opposite sex. Another difficulty is that interest in the opposite sex and the ability to get along with them does not develop in a vacuum. Youngsters need practice. Indeed, if parents keep teen-agers from having companionship with the opposite sex they deny them the opportunity of "shopping around" by having experienced the friendship of quite a number of those of the opposite sex of their own age. The danger here is that such boys or girls later on will "fall" for some silly, vapid creature because they have no standards by which to judge. Such standards come from experience.

Another fiendish practice on the part of parents is to place women on pedestals as demi-goddesses who are too fine, too fragile, too sacred to be treated in any manner except on an impossibly high plane. Women are not meant to be goddesses. They are meant to be the companions and partners of men. They must be evaluated in terms of companionative and unselfish human living. They aren't all wonderful. They are human—good, bad and indifferent as men are.

Still another practice on the part of parents is to try to train their adolescent boy in the theory that he must treat all women as his mother or sister. This is definitely a mistaken idea. Boys in our society are not supposed to fall in love with their mother

or sister or to have sex relations with them. This device which is used by mothers is subtle and devilish as it often drives boys to prostitution and to abnormal sex interests. Such cases are well known to those who do clinical work.

The last point to be dealt with in this article is the one where mothers tell their daughters how beastly men are and give them an idea that all men are villains. In order to protect them they fill them full of fears. Careful, frank sex education is a much more wholesome procedure, and a frank discussion is more apt to lead to the development of sound ideals and standards.

This article has dealt mainly with the ways by which parents hinder their adolescent children from making wholesome adjustments to the opposite sex. Obviously there is a positive side to the picture. This is planned education in family living. The giving of the facts of reproduction is not enough. Such information should be given in the larger setting of education for family living. In this phase of education both the home and the school have important parts to play. We must remember that facts alone do not constitute salvation. It is rather the attitudes and feelings which people have toward the whole matter that are important. In this particular phase of the adolescents' education something intelligent should be done rather than leaving the whole matter of sex-guidance to chance or to the influence of those who are already warped in their attitude toward the subject.

* * * * *

Coordinating Committee for Health Education.—The State Health Department and the Department of Education of West Virginia have jointly set up a coordinating committee for health education. The principal objectives are to study recent developments and trends in health education, including school community organization for health education and health welfare, community resources for health education, functional activities for students in health education, and health education materials. Health education workshops are being offered at the summer terms at West Virginia University, Marshall College, West Virginia State College and Bluefield State College. Undergraduate and graduate credit on renewal of teacher's certificates will be given for the two weeks spent in the workshops. Consultants will be specialists from the state health department, the department of education and various colleges. The courses offered are designed to aid school administrators, nurses, community leaders and teachers interested in health education to obtain assistance and guidance in developing plans for improving health programs in accordance with modern health education procedures. Journ. A.M.A., May 4, 1946, p. 51.

"SCREENING," EYE EXAMINATIONS, AND FOLLOW-UP

(*Continued from May Issue*)

An ingenious device for using Maddox rods for screening purposes has been developed under the auspices of the Massachusetts Department of Public Health as a part of the battery of tests known as the Massachusetts Vision Test. When a light is viewed through the type of lens known as a Maddox rod, it is seen as a streak of light, its direction being determined by the rods of the lens. In the Massachusetts test two pairs of spectacles are used, each with a Maddox rod for the right lens only, one to produce a horizontal streak, the other a vertical. The light is set in a small opening in a chart, which is drawn to resemble a house with the light in a window. This house-chart conforms to a definite scale so that, if the streak is seen outside of a specific area, it indicates what is considered a significant degree of muscle imbalance. This test is made at a distance of 20 feet, and a similar one with a small block and a pinpoint of light is made at 16 inches.

While some authorities recommend this test for muscle balance in the central position, others prefer the cover test.

Convergence can be tested by having the person watch a pinhead slide along the edge of a rule toward the bridge of the nose. The rule is placed with the zero end against the side of the nose, slightly below eye level. Normally, the approaching pinhead can be watched until it is about three inches away, when the eyes will be seen to diverge or the person will complain of seeing double or of being unable to continue looking at it.

Tests for color vision should be such as not to necessitate the naming of colors. As extensive research is underway on the development of satisfactory color-vision tests, it is not possible at this time to make conclusive statements on this subject or to recommend specific types of tests. To date, the most accepted types have been those in which: (a) Colors must be matched; and (b) patterns formed by colored dots must be distinguished from a background of similar colored dots. Matching tests have the disadvantage of having to be made with materials which become soiled and discolored through handling, while the pattern type may not offer true colors. Lighting is extremely important in color-vision testing, and new recommendations undoubtedly will call for a specific intensity, color, and arrangement of light.

When included in screening batteries, the depth-perception tests most commonly employed are those designed to be used with a stereoscopic instrument. Such a test consists of cards bearing test objects so designed that, when viewed with both eyes through

the lenses of the instrument, some of the objects should appear nearer than others.

Other simple depth-perception tests which do not require such elaborate equipment are, however, available. A very gross test can be made by giving the subject and the tester each a white-headed pin with a dark shank, mounted in a dark rod about the length of a penholder. The subject faces at about arm's length a black wall against which the tester holds his pin. The test consists of ascertaining whether the subject can touch with the head of the pin he is holding the head of the pin held by the tester. This is done in the direct line of vision and in several areas of the visual field, while the head is held still and only the eyes are moved. Normally it should be possible to do this at each point. Although failure in this test indicates very little, if any, depth perception, passing the test gives no evidence of the degree of stereopsis. The test is, therefore, supplemented by another in which the person is expected to recognize the relative nearness of white-headed pins projecting varying distances from a black, octagonal-shaped board viewed from a specific distance.

While these test materials can be easily improvised to give valid results, they must be designed according to scientific principles.*†

At present there are two instrumental batteries of tests commonly used in screening. Both of these employ test charts, to be viewed in a stereoscope (an instrument with binocular lenses), designed to discover the standard of performance of such visual function as central visual acuity (distance and near), muscle balance, fusion, depth perception, and color vision. One of these instruments is available only to industries, and only by specific arrangements with the manufacturing concern. The other may be used by any group.

Opinions vary as to the desirability of a stereoscope as an instrument for screening. Some ophthalmologists have found it satisfactory, when properly used by a well-trained technician, while others believe its use for screening is undesirable. As the findings need expert interpretations, such a device should be used only under the guidance of eye specialists.*

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*Davidson, Morris, M.D. A Simple Device for Measuring Stereopsis. *American Journal of Ophthalmology*, Ser. 3, 18: No. 4: 356-359: April, 1935.

†Davidson, Morris, M.D. Traumatic Ophthalmoloplegias as Workmen's Compensation Problem. *American Journal of Ophthalmology*, Ser. 3, 18: No. 11: 1030-1035: November, 1935. (For description of Perlia Test.)

*Further information on these devices and their use in schools and industries may be obtained from the National Society for the Prevention of Blindness.

Group tests owe their popularity to their economy of time. As is obvious, however, only a few of the screening procedures described can be given in a group. Even in making a Snellen test, much valuable information is bound to be overlooked in the simultaneous test of a group, since it is impossible to watch each person carefully, to see that all are fully co-operating, and to note signs of eye difficulty in reactions during the test. Further disadvantages include variations in the distances and angles at which the charts are viewed, and in the lighting in different positions in the room.

After the tests and observations are completed, those whose eyes seem normal should again be advised of the inconclusive nature of these procedures and urged to seek an eye examination if, at any time, they have any reason to suspect it is needed.

To those who seem to have deviations from normal, it should be explained that the screening procedures seem to suggest the presence of an eye difficulty; but that this can be determined only through a careful examination by a competent eye specialist who will also know whether treatment is needed and, if so, of what type. Because of the popular misconception that glasses are the cure-all for eye difficulties, care should be taken not to imply that they are needed.

Interpretations of the findings resulting from tests are best made in a personal interview, which allows also for correlating the advice with discussion of general health, school progress, vocational guidance, or industrial placement. It also affords opportunity for learning of attitudes, reactions, or situations which may have bearing on the matter, and for discussing arrangements for the examinations. If possible, the individual should be referred to the family physician for guidance in selecting an eye specialist. When this is not feasible, a list of eye specialists or clinics may be given and, when necessary, the person may be directed to a social agency for financial assistance.*

When a personal interview is impossible a printed form is usually employed. This should be carefully prepared to give the desired information, without any of the undesirable implications as to certainty of the presence of an eye difficulty or its probable nature and treatment. Although the personal interview is usually more successful than the printed form in encouraging prompt action, the matter should not be considered closed even after plans

*For information on agencies assisting in such matters, apply to the National Society for the Prevention of Blindness.

are made. Many delays may occur, and further encouragement and guidance may be needed.

A comprehensive eye examination aims to discover the condition of the eyes and related structures, the degree of visual performance, and the underlying causes of any difficulties found. An examination by a well-qualified specialist may furnish important clues to disturbances of general health.

A careful examination includes: family and personal history of health and of eye difficulties; inspection of external and internal structures of the eyes and of surrounding tissues; and measurement of the various aspects of visual functioning. The cornea, anterior chamber and lens may be examined with a slit-lamp and binocular microscope; and the fundus, with an ophthalmoscope which illuminates the interior of the eye, permitting a careful inspection of the retina and optic disk. Palpation may be used to determine the hardness of the eyeball but, if abnormal intraocular tension is suspected, tension may be obtained through use of an instrument called the tonometer, which is placed on the cornea (after instillation of a local anaesthetic).

The diagnosis of a refractive error is made in terms of the type and strength of lens required to neutralize the error and permit sharp focusing of the image on the retina. For this a retinoscope may be used to determine what type and strength of lens will focus its light on the retina. This objective measurement is supplemented by the use of trial lenses to find the exact correction which gives the most comfortable and satisfactory vision.

To prevent accommodation from interfering with accurate measurement of refractive errors, it is often necessary to instill a drug called a cycloplegic in the eye before making a refraction. This relaxes the ciliary muscles and dilates the pupil. As accommodation is most active in youth, a cycloplegic is used chiefly with young people. When dilation of the pupil alone is desired, the drug used is a mydriatic. After the refraction is measured, a miotic may be instilled to neutralize the effects of whichever drug has been used.

Muscle balance may be tested in various ways. Measurement of abnormalities is made with prisms, the degree and type of defect being indicated in prism diopters. Tests are also made of fusion, and sometimes of depth perception and color vision. When the need is indicated, the fields of vision may be measured with an instrument called a perimeter, or with a tangent screen; both of these provide exact information regarding the functioning in the areas of the visual field.

It is obvious that such an examination can be obtained only from a qualified eye specialist and that the care and treatment of eye conditions call for a high degree of knowledge and skill. As the term "eye specialist" may refer to anyone who specializes in any aspect of eye care, it is well to define the terms used to describe the major groups of workers in this field. They are:

Ophthalmologist and *oculist* are synonomous and designate a physician who has specialized in the treatment of eye diseases and optical defects. Such a person is, of course, licensed to practice medicine and surgery in all its forms, including the prescription of glasses when indicated.

Optometrist indicates a non-medical practitioner licensed to treat optical and muscle defects of the eyes without the use of drugs or surgery. He may prescribe glasses and give muscle exercises. Status may be designated by the initials O.D. (for Doctor of Optometry) or the word "optometrist" after the name.

Optician refers to a person who grinds, fits, and supplies glasses. This involves making facial measurements, selecting and grinding lenses according to prescription, polishing and fitting them into frames, and adjusting the frames to fit the wearer.

Orthoptist designates a technician trained under the guidance of the American Orthoptic Council and certified by this group to give orthoptics, under the direction of an ophthalmologist.

After the eye examination, assistance is often needed to encourage and guide the patient and family in carrying out the recommendations, and to plan and arrange for such continued help and supervision as may be indicated. Even in the simple matter of wearing glasses, people often need information regarding their correct use and the importance of periodic re-examinations and refitting of frames. Sometimes they need help in overcoming prejudice against wearing glasses.

Intelligent follow-up requires an exchange of information with the specialist and any co-operating agencies, at whatever intervals are necessary. Second-hand information received through patients, families or other laymen is seldom reliable and leads to many misunderstandings. Direct contacts with the examiner, medical social worker, or nurse on his staff, offer the best opportunity for ascertaining the nature of the problem and the advice given. Contacts such as these offer opportunity for giving return reports of progress or new developments. When personal interviews are not

feasible, written reports may be substituted. Similar arrangements should be made with any community agencies co-operating in providing care.

The scope of the follow-up needed will, of course, vary with the situation: the wishes of the doctor in charge, recommendations made, and needs of the patient and family. Often, interpretations must be made to families, employers, and other interested persons as well as to patients. This is especially true in the more serious types of eye conditions and those in which care and adjustments may be needed for a long period of time. Obviously, ethical standards, the doctor's wishes, and the understanding of the person addressed, should determine what information is given. The patient's wishes must naturally be considered in interpreting his problem to others.

In conditions of long duration, frequent encouragement is often needed to keep the patient under continuous supervision by the doctor, and to help him and the family to follow recommendations and to make necessary adjustments. When home treatments are ordered, a demonstration of proper techniques by a nurse using home equipment is often the most effective means of making sure that the recommendations will be properly carried out.

While office interviews will suffice for much of this follow-up, home visits are an invaluable supplement, since they make possible an understanding of the situation and of the family attitudes and resources that can be gained in no other way. In addition, demonstrations in the home are more effective than when given in the office.*

* * * * *

School Health Advisory Council,—On April 5 the Public School Health Advisory Council was formed to provide health service to Rochester, N. Y., children under a new cooperative program of medical and sociologic authorities. Herman J. Norton, director of health education in public schools, is Chairman of the new council, which is composed of public health authorities, board of education officials and members of medical and sociologic departments of the University of Rochester. The Rochester *Times-Union* states that the group will be a joint policy making and advisory group without administrative functions. Journ. A.M.A., May 4, 1946, p. 50.

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*Chapter V of forthcoming volume, *Eye Health—A Teaching Handbook for Nurses*, published by the National Society for the Prevention of Blindness. Reprinted by permission from the *Sight Saving Review*.

THE SCHOOL HEALTH SERVICE PROGRAM—A TALK TO PARENTS

MISS DOROTHY TIPPLE
West Winfield Central School, Winfield, N. Y.

My usual point of contact with the parents is in the home. I would like to tell parents about the various health service activities that go on in the school.

The school health program may be divided into three phases of activity:

1. Provisions for healthful school living.
2. Health and safety instruction.
3. Services for health protection and improvement.

The school accepts the responsibility of providing an environment in which the pupils may live healthfully, from a physical, social and emotional standpoint. The school building, in construction and maintenance, meets with certain standards in safety and cleanliness. Children are offered a varied program planned to give each child some opportunity to experience success; the classrooms are kept free from tension and unpleasantness; and emphasis is on group cooperation rather than competition among individuals. Standards are established regarding the health of the school personnel, including cafeteria workers. A school food service is maintained. Its primary objective is good nutrition. Secondarily, it offers an opportunity for the development of good eating habits. As it is partially supported by federal aid, the same service can be offered to all children whether or not they are able to pay.

Health and safety instruction stresses the development of good habits and attitudes as well as the acquisition of knowledge. On the elementary level, health instruction is the classroom teachers' responsibility. A great deal of incidental teaching is done and emphasis is placed on development of desirable habits and attitudes. In Junior high school, instruction is carefully coordinated with other subjects, science, homemaking and social studies. In Senior high, one full year of health instruction is given on the 10th or 11th year level. An effort is made to review, re-emphasize and point up the teachings received previously. The point of view is established that each student is responsible for preventive and corrective measures that will lead to the maintenance of his health status at its highest level. Emphasis is placed on personal health problems and mental health.

Through the cooperative efforts of the teachers, the school physician, Dr. MacNaughton, the local dentist, Dr. Dutton, the

dental hygenist and various community agencies, the school health service is able to conduct many activities for the protection and improvement of student health.

A physical examination is given to each student every fall by the school physician. Following this and a visual test and a measurement of height and weight, a report is sent to the parents concerning all remediable defects. Correction of these defects is the responsibility of the parents. A follow-up service maintains a check on corrections. Hearing tests and color perception tests are given during the year. In addition to the annual physical exam, the doctor examines boys for participation in sports and holds a pre-school and immunization clinics in the spring of each year.

An annual chest x-ray is made possible for all students fifteen years and over through the Herkimer County Tuberculosis and Public Health Association. This replaces the former program of skin-testing and x-ray only for selected cases.

Our immunization program includes protection against smallpox and diptheria. Annual clinics are held for this purpose.

The school offers a service of dental correction in cooperation with Dr. Dutton. It makes his service available to all students during school hours for the entire school year. Children below the sixth grade are taken to and from the dentist's office. Red Cross funds have assisted greatly in carrying out this program, as well as the correction of other defects.

A program of individual health counseling is maintained for all students above the fourth grade. Each child is given an opportunity to look over his health record, explanations of the record are made, any defects are pointed out and an attempt is made to formulate a definite plan for the correction of such defects.

There are many community agencies whose services we employ. I mentioned the local chapter of the Red Cross. It has been very generous in placing funds at our disposal for correction of defects. The Herkimer County Tuberculosis and Public Health Association carries the entire responsibility and expense of the x-ray service. In addition, it offers a film service, other educational aids and the use of such exhibits as we have in the corridor tonight. The State Department of Mental Hygiene offers us a monthly psychiatric consultation service in Herkimer. The State Department of Health holds monthly orthopedic clinics in Utica or Little Falls. Children with hearing difficulties may be taken to the State School for the Deaf at Rome for special testing and recommendations.

Cumulative health records are maintained for each student,

and a copy is forwarded to the new school when a pupil changes his place of residence.

First aid for emergencies includes immediate care, getting pupils home and guiding parents, where necessary, to sources of treatment.

The home visiting program serves to check on illness absence, to follow up correction of remediable defects, and to consult with parents on any health problems which their children may have.

Effort is made to prevent and control communicable disease by continuous daily observation on the part of the teachers, by removal from school of all children who become ill during school hours and by re-admission via the health office of children who have been absent due to illness. In the control of communicable disease there is always the problem of bus transportation. Children frequently arrive in school with a communicable disease which has escaped detection at home or the child is sent to school for diagnosis.

The work of the dental hygienist includes examination and cleaning of the children's teeth and sending of a notification to the parents concerning the defects found.

This concludes the survey of the health program. The first problem that I selected to bring to your attention is that of the dental health of our students. The problem, briefly, is that of the number of defects found is consistently above average in spite of a program of dental correction that maintains a high average of corrections.

The factors that are usually considered the most important in the prevention of dental defects are: (1) adequate dental supervision of first and permanent teeth, (2) a well-balanced diet including milk and milk products, fresh vegetables and fruit and cod liver oil and (3) correct brushing of the teeth at least twice daily. In attempting to find the source of our difficulty, it would seem that between the home and the school, we are least somewhat deficient in all respects. First, it is evident that there is not adequate dental supervision of baby teeth. This should begin at the age of two to two-and-a-half years. Proper care of first teeth ensures stronger and straighter permanent teeth. Our dental program may provide adequate care for permanent teeth, but the earlier phase has been neglected. Moreover, the habit of going to the dentist at regular intervals is more easily taught to the young child. As far as the possibility of a dietary deficiency is concerned, this responsibility belongs largely to the home. The one meal given in school is carefully planned to meet the child's needs.

Parents must be equally sure that the other meals supplement the noon meal adequately. It is my opinion that the area in which our children are the most remiss is in daily brushing. Of the 555 students who had their teeth cleaned by the Dental hygienist this year, only 229 claimed that they brushed their teeth at least once daily; twenty-nine said they never brushed their teeth and the remainder stated that they brushed their teeth "at times." This would indicate that the school needs a more emphatic dental health education program wholeheartedly supported by a home teaching program and supervision, leading to the establishment of better habits.

The second problem I would like to present to you is that of immunization. I mentioned before that the immunization program includes protective measures against smallpox and diphtheria. Our record shows that there are in school 113 students who have not been vaccinated, 199 in need of re-vaccination and 98 who have not been inoculated for diphtheria.

I believe that the solution to this problem is to be found in greater cooperation between the school and home in planning a program of immunization. Every child should be immunized for both diseases before the age of one year, he should be re-vaccinated and receive a "booster" dose of diphtheria toxoid before entrance to school and should be re-vaccinated at the age of twelve. It might be necessary to increase the number of immunization clinics. I would be in favor of requiring these procedures to be done before entrance to school is allowed. It would be valuable also, to have a record, of which the parent has a duplicate, to give dates and kinds of immunization.

The third topic—education for family life—is one of our outstanding health problems. We recognize that instruction for family life, adapted to the interests of the child, should be part of the general course of instruction and should be recognized in specific courses on the junior and senior high school level. We are also aware that the school should provide boys and girls with information and guidance on such subjects as marriage, homemaking and parenthood. In addition, sex education should be continuous throughout a child's life, scaled to meet his different needs at different ages. At the present time, other than incidental teaching, the only specific instruction on this subject is given in homemaking classes in junior and senior high school—almost entirely in junior high. During the school year, seventy girls will receive some instruction in family relationships. On the senior high level, no instruction is given to girls unless they take homemaking and no

provision is made for any instruction for boys. The home, church, school and other community agencies have a joint responsibility and should cooperate in this undertaking. The specific difficulties in setting up a school program are: (1) Cooperation with and consent of the parents in establishing the form and content of instruction; (2) actual placement in the curriculum—it is desirable in junior and senior high to integrate it with other courses of instruction and yet boys and girls should be segregated and (3) in setting up the program, there must be teachers with special training in this field and there should be, in addition, carefully planned teacher and parent study groups.

These problems that I have set forth were selected, not only because they are oustanding from our point of view, but because their solution rests in cooperative home and school activity. We would appreciate any suggestions or assistance at any time that this group might have to offer.

* * * * *

Sprains in Athletes,—*To the Editor*: I was interested in your reply in the March 9 issue of *The Journal* to the query of Dr. D. L. Hollis of Biloxi, Miss., regarding the procaine injection of ankle sprains in football players.

While procaine is useful in the treatment of certain minor sprains in non-athletes, the experience of this department for the past ten years, based on the treatment of approximately 75 ankle sprains a year in athletes, has led to the conclusion that it has no place in the treatment of any sprain sustained in contact sport.

A sprain is a partial rupture of a ligament. When the protective function of pain is eliminated by procaine and the ligament is subjected to the violent stresses and strains of football, the partial rupture might well became complete.

Furthermore, it was found some years ago in a small experimental series that the contact athlete whose ankle ligaments had been anesthetized lost his sense of timing and coordination, played badly and was more likely to sustain other injuries. One varsity halfback, who played badly and briefly with a procainized anterior tibiofibular ligament sprain, stated after return to the bench that while running he had no sense of the position of his ankle in space.

A complete exposition of this point of view regarding the diagnosis and treatment of sprains in athletes will be found in "Athletic Injuries" by Dr. Augustus Thorndike, Philadelphia, Lea & Febiger, 1938. Thomas B. Quigley, M.D., Boston, Surgeon, Harvard Athletic Association. Journ. A.M.A., May 4, 1946, p. 61 .

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EDITORIAL

The report* of the Harvard Committee discussing present conditions in education there and elsewhere, and attempting to draw definite conclusions, and to set up definite suggested curriculum inclusions has aroused great interest, much discussion, and some heat.

All these results are to be expected in discussions of a report which may affect so deeply procedures, standards and curricula both in secondary schools and in those of higher educational levels.

Defenders of the "elective" system seem particularly disturbed although the committee suggestions would still leave broad elections. These, however, would be pushed largely into the Junior and Senior years. Perhaps two additional years of age might cause better selections, made on a more intelligent basis than has been the case.

In a field as broad as this of higher education, it is extremely difficult for any committee in a report of moderate length (267 pages) to cover all the ground. The criticisms have been largely that there were omissions here, or too little emphasis there. Even the definitions of the Committee are attacked. Much of these criticisms seem to this editor close to hairsplitting.

One commentator criticises the omission of any suggestion of the need of "knowledge and habits that will best promote perfect health." More power to him, but he does not touch on the moot

*"*General Education in a Free Society*": Report of the Harvard Committee, Harvard University Press, 1945.

point—what is to be omitted or condensed from our present secondary school program in order to make room for these badly needed knowledges and habits.

The fact is, of course, that any recommendation for change hits somebody's sacred cow—a cow that, unfortunately, is so sacred that its worshippers resent any discussion of the possibility of improving the breed.

One great difficulty in getting a more generally accepted idea of the subject discussed is the language difficulty. Often different people use the same words, but mean different things. To some it seems that, in the field of education, more specifically in education of teachers to help them to practice their profession, there is a particular vagueness that makes clarity of understanding extremely difficult.

Simplification of words and phrases would help our thinking—that of the writer as well as that of the reader. In the sciences we get an approach to this. The words may be long, but they are definite and complete. Law at one time had such a vocabulary, but today pettifogging and lack of clear ideas, or the ability to express them, has landed us in a predicament where even the United States Supreme Court can seldom agree on what a given law means. Medicine had it, but is in danger of losing it. This is due largely to poor teaching. To rattle through a discussion of a disease, using only the name of some one who was one of its early describers is snobbishness, not erudition. Scientific titles are definite and descriptive. Any properly trained doctor of medicine knows what "Thrombo-angiitis obliterans" means, but what proportion of them know what "Buergers' disease" is?

Two things make Lincoln's Gettysburg address a great masterpiece of English diction: he has a clean-cut idea, and he expresses it without superfluous words. Had he used three times as many words, it is probable that the speech would never have been heard again, any more than has that of the great orator who also spoke on that program. By the way—Who was he?—*C. H. K.*

* * * * *

SURGICAL TREATMENT OF INTRACTABLE PLANTAR WARTS

J. A. DICKSON, M.D.

The majority of plantar warts are successfully eradicated by conservative measures such as escharotic solutions, electro-desiccation, or irradiation in the form of X-ray. Comparable results are obtained by each of the above methods, 60 per cent to 90 per cent cures. Escharotics are reserved for simple cases, and electro-desiccation and irradiation are employed when local application of

these substances fails. If a single method is desired, the selection would undoubtedly be X-ray, for this treatment is painless, short, successful, and safe, provided the treatment is administered with due respect to the tolerance dose.

It is recognized, however, that no matter how skillfully used, these methods fail in at least 10 per cent of cases. These intractable problems are not only distressing but often calamitous to the patient. After many years of therapy extremely painful ulceration on the plantar surface of the foot may still persist. This ulcer invariably extends through the deep fascia, and the dermatologist and roentgenologist feel that they have run the gamut and that further cautery, X-ray or radium treatment is contra-indicated.

For this type of plantar wart the only recourse is removal of the wart area in its entirety, and while this in itself presents no difficulty, the restoration of the operative sight to a painless weight-bearing area involves many surgical problems. The amount of tissue removed may make immediate closure impossible, and even though approximation of the skin edges can be accomplished, it is performed under such tension that the resulting scar becomes thick, unyielding, and painful. Full thickness grafts, pedicle transplants from the involved foot or opposite calf, though successfully transferred, retain the characteristics of the donor site, and the thin skin does not furnish sufficient protection to weight-bearing.

In many instances, even though the defect could be sutured without undue tension, or a full thickness graft could be successfully transferred, the pressure of the overlying metatarsal head gradually transforms the operative scar and adjacent weight-bearing area into a dense, painful cicatrix as productive of symptoms as the original wart.

I thought that the removal of a V section of the foot, including a wide excision of the wart with a toe and the corresponding metatarsal bone, would bring about the desired effect. This operation would allow primary closure without tension and eliminate the use of grafted skin. Removal of the metatarsal bone would convert the operative site into a non-weight-bearing area, and healing without a painful scar would be accomplished.

At first it seemed heroic treatment to remove a section of the foot to cure a wart, but these intractable warts are serious problems and require radical treatment.

The loss of the toe and accompanying metatarsal bone did not appear to interfere in any way with the normal function of the foot. In both cases it will be noted that postoperatively there is a soft, pliable scar. The weight-bearing surface is much more satisfactory than when grafts were used to bridge the defect.

Reprinted from the Cleveland Clinic Quarterly, April 1946, p. 92.

ABSTRACTS AND NOTES

School Health a Specialty,—The modern school physician is a trained expert. He is engaged in school health work because he is interested in children, in preventive medicine and constructive medicine. His vision goes beyond repairing mistakes of the past, and he looks to the future for more and more effective ways to keep children healthy so that they may become healthy adults. The true school physician is not just another doctor who takes a flier in school health work to gain experience or build up a practice. He looks upon his work as a dignified specialty in preventive medicine. He is more interested in preventing diseases and disabilities than in curing them.

School health work has become one of the indispensable services of our modern civilization. No other agency can take its place. At the same time it does not duplicate or supplant the work of any other public or private service. It takes nothing from the work of the practicing physician. In fact it adds greatly to his work because thousands of children are referred to their family physician every year for treatment and correction of defects. Those children who must go to public clinics are saved from suffering and permanent disability. If it were not for the school physician, ably assisted by the school nurse, many of these children would go on to a sickly adulthood and some of them would fall by the wayside. During the depression from which we were "rescued" by World War II we heard a lot about "the forgotten man." The school physician is the champion of the forgotten child.

The school health program makes it possible for every child whose parents are willing, to have a periodic health examination. It fits naturally into the larger educational program. If there were no school health program, how many children would receive such an examination? Very, very few. How many people would pay a private physician for such a service? How many people in the "lower brackets" would take a child not acutely ill to a public clinic? Experience teaches us that not one in a hundred would do so. How long would it take to educate the public to do this? At present the school physician is largely concerned in such education.

The school physician feels himself responsible for everything that directly or indirectly affects the health of our school children. He investigates the sanitation of the school buildings, especially that of the cafeterias. He is interested in seeing that the children are not overburdened with studies and that they do not attempt sports and games beyond their strength. He knows when a child needs rest rather than activity. He sends children home who are

a menace to the health of their classmates or who are too ill to be at school themselves. He is concerned with the health, and therefore the efficiency, of their teachers. He thus keeps the health of the whole school population at a higher level, helps to prevent unnecessary absences, the repeating of grades by children with correctible health handicaps, and so cuts down greatly the cost of educating our children. Furthermore, it goes without saying that a healthy adult population, as a result of a good start in school, is less expensive to society. There is greater industrial and business efficiency, less poverty and crime, and a higher standard of living. Abstracted from The School Physician—Is He Necessary, by John L. C. Goffin, M.D., as it appears in *Health Education Journal, Los Angeles City Schools*, December, 1945, page 14.

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"Tuberculous" Or "Tubercular,"—The term "tubercular" came into use long before the tubercle bacillus was discovered by Koch in 1882 and was used originally as its etymology implies, to indicate a morphological appearance of a nodular character in the tissues of animals. When men began to study consumption more carefully and found out something about the characteristic nodular formations that appear in the tissues of the body wherever the disease is present, very naturally the word tubercular and in fact the term "tuberculous" began to be used to designate these morphological appearances. They came to be synonymous and interchangeable. This condition existed generally up until the end of the 19th century.

Gradually however, as workers in the field of tuberculosis began to distinguish between "tuberculous" conditions that were caused by the tubercle bacillus and "tubercular" conditions caused by something else, such as a growth, a foreign body or some other type of bacillus, it became necessary to have an adjective that would differentiate not so much the appearance but the cause of the tubercle. Hence the term "tubercular" first came into use among laboratory workers as a distinguishing adjective to designate nodular appearances in the tissues, or tubercles, that were not caused by the tubercle bacillus. At the same time the adjective "tuberculous" came to be used exclusively for tubercles or processes that were caused only by the tubercle bacillus.

At the second annual meeting of the National Tuberculosis Association, the necessity for clearly defining these two terms was recognized and the following resolution was adopted:

"RESOLVED, That in the interests of clearness and uniformity of nomenclature the Association employ in its official publications the term "tuberculous" to refer to lesions or conditions caused

by the tubercle bacillus and the term "tubercular" to describe conditions resembling tubercles but not caused by the tubercle bacillus."

From this resolution it will be seen that "tuberculous" is the adjective corresponding to the noun "tuberculosis," while "tubercular" means a process or condition resembling but not actually tuberculosis.

In spite of publicity given to these facts however, the faulty use of the term "tubercular" still continues. Hardly a day goes by that the National Association does not receive correspondence or other matter using such terms as "tubercular patients," "tubercular condition," "tubercular infection," or even (horrible dictum) "tubercular sanatorium."

The term "tubercular patient" if it means anything at all, must indicate a patient who has some form of disease that is not caused by the tubercle bacillus. A patient for example with blastomycosis might be said to be "tubercular, i. e., resembling tuberculosis," but a patient with tuberculosis in any form, whether in the lungs or in the joints should not be designated as a "tubercular patient." By common usage, the term "tuberculosis" has come to be recognized as an adjective as well as a noun and we commonly speak of a patient as a "tuberculosis patient," as we do of a diphtheria or a pneumonia patient. This is prefectly good English and is absolutely clear, if the condition described is one caused by the tubercle bacillus.

So also the use of the term "tubercular condition" as it is commonly used by physicians and others in ninety-nine cases out of one hundred is incorrectly used. In probably one instance out of one hundred the writer or speaker means what he says, namely, that the condition under consideration is caused by a nodular growth of an organism, or an inanimate body other than the tubercle bacillus. A tuberculous condition is a condition caused by the tubercle bacillus and this is what is usually meant.

Even the dictionaries are at fault in definitions to this character and give illustrations to bolster up the faulty use of "tubercular" taken from medical literature as far back as the 18th century and the first half of the 19th century. Nor are the medical dictionaries very clear in their positive distinctions of the terms, "tuberculous" and "tubercular."

The use of terms in England and in British literature generally is also not at all clear. In most instances British authors use the term "tubercular" as synonymous with "tuberculous" and in the few cases where "tubercular" is used as it should be the reader is apt to be misled because of the practices of other writers in this regard.

In the name of accuracy, therefore, it is hoped that tuberculosis patients, physicians, nurses, secretaries and others who have occasion to talk about tuberculosis will not only themselves use the terms "tubercular" and "tuberculous" correctly, but will also urge the correct use of these terms upon others. Philip P. Jacobs, *Itam*, April 1946, page 7.

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School Health Cooperation.—Through the constant teamwork of the teachers, the public health nurse and the student health council, the foundation has been laid at the Niles Township High School for what should develop into a successful *total* school health program within the next few years. The building blocks upon which the program is being fostered are as follows:

1. The functions of the public health nurse in the school health program were outlined and each teacher familiarized himself with the nurses' duties.

2. The functions of the teachers were likewise outlined and accepted by the group.

3. An outline of the aims of the school health program, covering both health services and other phases of health education, was developed in cooperation with the department of physical education. The Twelve-Point Four-Year Program which resulted is the procedure being followed today. These twelve points are:

(a) A medical examination by the school physician of all new students entering high school for the first time.

(b) The weighing and measuring of each student each semester.

(c) An annual visual acuity testing program.

(d) An audiometer testing program in the freshman year, repeated in the junior year.

(e) A plan for immunization against diphtheria.

The Schick test was offered to everyone this year and will be offered to every freshman class thereafter. Positive reactors to the Schick test will be offered immunization.

(f) A plan for vaccinations against smallpox.

Offered everyone this year vaccinated more than five years ago and every year thereafter to freshmen and new studnts.

(g) A plan for tuberculin testing and follow-up.

The Mantoux test offered to everyone this year followed by a chest X-ray for positive reactors.

(h) The annual requirement of checking each student's posture.

(i) An annual dental examination in cooperation with the Chicago Dental Society.

Recommendations are made individually at the time of the examination and another examination in 6 months is recommended.

(j) Inclusion of venereal disease education for senior students.

Parent's permission for taking venereal disease education, in addition to permission for blood testing, is included on the yearly request blank. This is one of the many services which the student and parent have a right to approve or veto.

(k) Health education via visual education.

Preceding each individual program films are shown to all students.

(l) The distribution to parents of a bulletin explaining the need for each individual program; the methods used; and the value of such a program to the students, family and community.

A student questionnaire is sent with the bulletin to the parents. The services which the parent wishes for his child are checked and the questionnaire is returned to the school.

4. Monthly discussion meetings of teacher, nurses and students for interpretation of what is taking place in the school health program and what each individual is expected to contribute.

5. Procedures were worked out for the control of communicable diseases. The student with symptoms or signs of communicable diseases is immediately referred to one of several individuals responsible for the exclusion of students who are ill. The student receives a signed exclusion pass which is taken to the office. It then becomes the responsibility of a member of the office force to call the parent to arrange for transportation and to request the parent to notify the school concerning the type of illness when determined. When a communicable disease develops in the school a bulletin concerning that disease is prepared and distributed to the teachers by the nurse.

6. Teacher-nurse conferences are held at regular intervals. The nurse confers with the teachers about the health needs of their students and suggests ways of meeting them. She interprets information from health records, home visits, and from conferences with students, physicians, dentists, or social workers.

7. Suitable, authentic reference material on the health needs of the students, on prevalent diseases or on recent research in the field of public health is given the teacher by the nurse.

The reaction of the students to the program has been most favorable as they feel they are not being *told* "how to be healthy," but they are actually practicing healthful living.

Condensed from papers presented at Niles Township High School P. T. A. Meeting. Dec., 1945 by: A. L. Biehm, Ph.D., Supt., Niles Township High School; M. A. Schaefer, M.A., Dept. of Phys. Ed. for Girls, Niles Township High School; Thelma Cline, R.N., B.S., Asst. Supv., Cook County Health Dept. *Illinois Health Messenger*, May, 1946.

* * * * *

Acute Myocarditis in Mumps,—Rosenberg observed a complete heart block in a sailor, aged 20, who was convalescing from epidemic parotitis. Diagnosis of acute myocarditis was made from the electrocardiographic changes, and, in the absence of any other etiologic agent, the condition was ascribed to the virus of mumps. Another patient was observed who, during the course of mumps,

manifested electrocardiographic evidence of partial heart block which progressed to complete heart block and ultimately returned to normal. In 104 consecutive cases of mumps in adults, electrocardiographic evidence of myocardial involvement was found in 16 instances (15.4 per cent). Mumps myocarditis appears as a rule between the fifth and tenth days of illness and is usually mild and transitory. In the majority of instances it follows a subclinical course and is recognizable chiefly, if not exclusively, by electrocardiographic studies. Precordial pain, dyspnea and/or palpitation appeared in four cases of this series and in the two reported in this paper. The author suggests that perhaps too much emphasis is attached to the delayed conduction time in the differential diagnosis of rheumatic fever. Other acute infections that are prevalent in epidemic form when the incidence of rheumatic fever is at its peak, such as pneumonia, diphtheria and German measles, were also found with electrocardiographic abnormalities, including a prolonged PR interval. The author also suggests that epidemic parotitis is a generalized infection and that any acute infectious disease, bacterial or viral in origin, is capable of affecting the heart. D. H. Rosenberg in *Archives of Internal Medicine*, as abstracted in Journ. A.M.A., April 27, 1946.

* * * * *

Courses for "Sports Physicians,"—The critical attitude of Swedish physicians has been evidenced in one of the greatest popular movements of this age, athletics. Because the physicians have refused to maintain that sports prolong life or protect from illness, they have been accused of obstructing the progress of sports* and of indifference to improving the health of the public. The result has been the development of quackery in connection with the physiology of athletics, training methods, diet and so on. Last year saw the development of closer cooperation between physicians and the sports movement, and far less indifference in Sweden. An important milestone was the opening of a so-called sports clinic at the Stockholm stadium in 1944, where a continuous control has been kept on athletics. Another measure of importance is the "ski doctors" course held during the winter at Storlien, the Swedish ski resort. In June, 1945, the first summer course for doctors interested in athletics was held at the Athletic College at Bösön, Stockholm. The opening session was attended by fifteen pioneering physicians representing all ages and categories, from beginners to older army doctors. Those taking part in the course participated in most of the sports themselves, receiving instruction from experts in each

*This sounds much like the attitude of many sophomoric alumni in the United States.

field on training, exercising, diet and theory. Lectures were held on medical problems in athletics, especially heart ailments. There was discussion concerning problems connected with the medical care of athletes and those indulging in sports in general. The course was pronounced a success, an enterprise to be continued and broadened. Journ. A.M.A., Feb. 23, 1946.

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Effect of Daily Vitamin Supplement on Children,—A total of 1,620 children aged 5 to 14 years attending elementary and secondary schools in Stoke-on-Trent and Salford were divided into two groups, one of which received on each school day for a year (1943-1944) a vitamin capsule containing vitamin A 4,000 international units, vitamin B 1 mg., riboflavin 2 mg., nicotinamide 20 mg., ascorbic acid 50 mg., and vitamin D 600 international units. The other group received a placebo free of vitamins. The vitamin supplement had no consistent effect on growth, strength, endurance, fatigue potential, incidence or severity of clinical conditions, hearing and absenteeism from school. In the analysis of the data, the children were grouped according to social, economic and nutritional status, but no effects of the vitamin supplement could be discerned on the aforementioned criteria. The vitamin supplement had a beneficial effect on gingivitis in Stoke, but not in Salford. Evidence from a further series of trials indicated that ascorbic acid alone has no beneficial effect on that condition. Dietary studies made in conjunction with the test showed that the average ascorbic acid intake in the diets was well below the intake recommended by the National Research Council (United States) and that many children probably had intakes of less than 10 mg. daily over long periods. The absence of effect of the vitamin supplement and the generally good nutritional state of the children threw doubt on the validity of the National Research Council standards. *British Medical Journal* as abstracted in Journ. A.M.A., May 11, 1946, p. 185.

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False Emphasis on "Perfect Attendance,"—The control of communicable disease in schools is sometimes hampered by placing false emphasis on perfect or near-perfect attendance. Rather than by giving certificates or awards for such dubious distinction, commendation should be extended to pupils who protect the health of their classmates by remaining at home when they are not well. Allotment of State funds to schools on the basis of the average number of pupils in daily attendance is equally bad practice because it makes teachers anxious to force attendance on pupils who ought better be at home and in bed. From *School Life*, U. S. Office of Education, March, 1946.

Protection Against Measles and Smallpox an Urgent Need,— New York State has been in the grip of a measles epidemic which promises to mark the year 1946 as one of record-shattering measles prevalence.

The prediction that measles incidence may reach unprecedented proportions is based on the already high prevalence coupled with evidence that it apparently is characteristic of the disease to alternate a year in which the number of cases runs high with one in which there are relatively few cases. In 1944 and 1945 there was an unusually low reported incidence of measles in New York State, 19,367 and 3,349 respectively, contrasted with a previous average of over 28,000 cases per year.

During March 1946, 12,037 cases were reported in the upstate area, the highest for any month since 1908, the first year for which statistics on measles prevalence in the State are available. The previous high for any one month was 10,481 recorded in May 1923. The total for March of the present year is in striking excess of both the figure for March 1945 (325) and the five-year average of 4,461 for the month during the period 1941-1945. The previous all-time high for March was 9,724 established in 1932.

Reports received up to April 9 show the outbreak is concentrated in five counties in which 74 per cent of all the measles in the State, outside of New York City have been reported. Monroe County led with 2,757 cases; Erie County had 1,803; Onondaga 1,759; Broome 1,472; and Nassau 1,055. These were the only upstate counties which reported more than 1,000 cases during the month. Each showed a considerable increase in measles over the preceding month with the exception of Onondaga where the number of cases dropped from the February figure (3,631).

Measles is gaining a foothold also in New York City where a minor epidemic has been spreading among children since January 1. During the last week of March, a total of 1,372 new cases was reported, the highest for any week this year.

The unusually high prevalence of measles throughout the State demonstrates the immediate need for intensive application of protective measures, particularly among children under the age of four years. Exposure to measles is especially hazardous to very young children since they are most liable to die from the disease and to have complicating pneumonia or ear trouble.

Human immune serum globulin (gamma globulin) is now available in moderate quantities for the protection of children under the age of four who have been exposed. It should also be given to other persons who for any valid reason should be protected against an attack. In general, 2 milliliters of globulin given intra-

muscularly within eight days after the initial exposure will prevent development of the disease in about 75 per cent of young children and will decidedly modify it in the remainder.* One ml. of the preparation given within the same period of time will usually prove to be effective in modifying measles if it does not prevent it. Modification is preferable in many cases since a permanent immunity may thus be established.

Dosages recommended by Janeway** are: .075-.1 ml. per pound of body weight to prevent, given as early as possible; .02-.025 ml. per pound of body weight to modify, given on the fourth or fifth day.

Immune serum globulin (human) may be obtained direct from the State Laboratory, Albany, and from local laboratory supply stations. *Health News*, New York State Dept. of Health, April 22, 1946.

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Safety in Childbirth,—Puerperal mortality in this country for many years occupied an unenviable position. The possibility of its prevention or reduction was often doubted. Deaths from childbirth were accepted as one of the unavoidable risks to which woman was heir. This conception has changed and in a recent article contained in the Statistical Bulletin of the Metropolitan Life Insurance Company (December, 1945) due credit is given to the various groups of interested physicians who combined to make a careful study of individual cases and did not hesitate to make public their findings. The original New York Academy of Medicine report was assailed at the time as visionary and unwarranted, but a reduction in the maternal death rate in New York City from 64 per 10,000 in 1933, to 17, or a decrease of 73 per cent, emphasizes the contention that improvement was possible.

There are deaths from childbirth which, even with our present knowledge, cannot well be prevented, but even this number is declining year by year as advances in medical research begin to bear fruit. One need only point to the introduction and wider employment of the sulfa drugs and penicillin. The medical profession may well be proud of the accomplishments developed through its own effort. *New York State Journal of Medicine*, April, 1946.

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Tuberculosis Certificates,—The mass certification of schools which have met the standards in Tuberculosis procedures set up by the American School Health Association Committee on Tuberculosis is progressing splendidly under the guidance of the committee. On May 9th there were certified at Granite Falls, Minne-

*Greenberg, Frant, and Rutstein. J.A.M.A., 126:944, 1944.
**Janeway. Bull. N. Y. Acad. Med., 21:202, 1945.

sota, more than 100 schools in the western part of Minnesota. Dr. Charles E. Lyght, of the National Tuberculosis Association, was one of the speakers. A large number of others are about ready for certification.

Dr. J. A. Myers reports that there are indications that other states are planning to undertake certification soon.

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Dr. Earl E. Kleinschmidt,—Former associate National Medical Director of the Red Cross and an authority in the field of public health and preventive medicine, has been appointed Director of the Tuberculosis Institute of Chicago and Cook County to succeed Mrs. Theodore B. Sachs who has retired, Dr. Clarence L. Wheaton, Acting President of the Institute, announced.

Dr. Kleinschmidt has been in the army medical corps since 1944. Prior to that time he was associated with the Red Cross, and was Health Commissioner of Toledo, Ohio. He has taught at the University of Michigan and Loyola University School of Medicine.

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MEETINGS

New York State Association of School Physicians will hold its annual meeting and conference in conjunction with the State Sanitary Conference sponsored by the New York State Department of Public Health, at Saratoga Springs, N. Y., June 24, 1946, at the Grand Union Hotel.

The American School Health Association, with the American Public Health Association, at Cleveland, Ohio, November 10-14, 1946.